



State of Delaware Health Plan Comparison Chart

(Effective July 1, 2018)

Please note: The specific premiums (rates) referenced in this document apply to State of Delaware employees. Flex credits offered to school district or charter school employees to reduce their employee premiums for health care are not reflected in this information. Please see your HR/Benefits Office for information about your flex credits. Employees who are eligible for and receiving reduced premiums due to double state share eligibility are not reflected in this information. State share and pensioner contributions depend on years of service and the date of hire/retirement. Non-State Participating Group Employees should contact their HR/Benefits Office within their organization for premium information.

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Type	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)		Preferred Provider Organization (PPO)	
Primary Care Provider (PCP) Selection	Recommended		Recommended		Required		Recommended	
Coverage Options/ Premiums (Rates)	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) <i>*State pays difference</i>	Total Monthly Premium (Rate)*	You Pay Monthly (Bi-Weekly) <i>*State pays difference</i>	Total Monthly Premium (Rate)*	
Employee	\$695.36	\$27.84 (\$13.92)	\$719.68	\$35.98 (\$17.99)	\$725.94	\$47.16 (\$23.58)	\$793.86	\$105.18 (\$52.59)
Employee & Spouse	\$1,438.68	\$57.52 (\$28.76)	\$1,492.22	\$74.58 (\$37.29)	\$1,530.58	\$99.50 (\$49.75)	\$1,647.34	\$218.26 (\$109.13)
Employee & Child(ren)	\$1,057.02	\$42.26 (\$21.13)	\$1,099.56	\$54.96 (\$27.48)	\$1,110.52	\$72.18 (\$36.09)	\$1,223.46	\$162.08 (\$81.04)
Family	\$1,798.42	\$71.92 (\$35.96)	\$1,895.74	\$94.78 (\$47.39)	\$1,909.82	\$124.12 (\$62.06)	\$2,059.40	\$272.86 (\$136.43)
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care/ Screening/Immunization (age, gender and risk parameters may apply)	100% covered, not subject to deductible	70% covered, not subject to deductible	100% covered, not subject to deductible	70% covered after deductible	100% covered	Not covered	100% covered	80% covered after deductible
Deductible (Per plan year)	\$500 per individual/ \$1,000 per family	\$1,000 per individual/ \$2,000 per family	\$1,500 per individual/ \$3,000 per family	\$1,500 per individual/ \$3,000 per family	N/A	N/A	N/A	\$300 per individual/ \$600 per family
Health Reimbursement Account (HRA)	N/A	N/A	\$1,250 per individual/ \$2,500 family	\$1,250 per individual/ \$2,500 family	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum (including copays and deductibles)	\$2,000 per individual/ \$4,000 per family	\$4,000 per individual/ \$8,000 per family	\$4,500 per individual/ \$9,000 per family	\$7,500 per individual/ \$15,000 per family	\$4,500 per individual/ \$9,000 per family	N/A	\$4,500 per individual/ \$9,000 per family	\$7,500 per individual/ \$15,000 per family
Prenatal and Postnatal Care	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	100% after \$25 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	Not covered	100% (inpatient room and board copays do apply to hospital deliveries/birthing centers)	80% covered after deductible

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Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
24/7 Nurse Line	Yes, no cost		Yes, no cost		Yes, no cost		Yes, no cost	
Primary Care Visit to treat an injury or illness	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	\$15 copay per visit	Not covered	\$20 copay per visit	80% covered after deductible
Telemedicine (Virtual Doctor Visits)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	\$15 copay per visit	Not covered	\$20 copay per visit	80% covered after deductible
Urgent Care Visit	100% covered after \$25 copay	100% covered after \$25 copay	90% covered after deductible	70% covered after deductible	\$15 copay per visit	Not covered	\$20 copay per visit	80% covered after deductible
Emergency Room	90% covered after deductible	90% covered after deductible	90% covered after deductible	90% covered after deductible	\$150 copay per visit (waived if admitted)	\$150 copay per visit (waived if admitted)	\$150 copay per visit (waived if admitted)	\$150 copay per visit (waived if admitted)
Chiropractic Care (Requires medical necessity and excludes preventive/maintenance care)	90% covered after deductible for up to 30 visits per plan year	75% covered after deductible for up to 30 visits per plan year	90% covered after deductible for up to 30 visits per plan year	75% covered after deductible for up to 30 visits per plan year	Lesser of \$15 copay or 20% coinsurance (Referrals required through PCP)	Not covered	85% covered for up to 30 visits per plan year	80% covered after deductible for up to 30 visits per plan year
Physical Therapy (Requires medical necessity)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	80% covered for up to 45 visits per illness/injury (Referrals required through PCP)	Not covered	85% covered	80% covered after deductible
Specialist Visit	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	\$25 copay per visit (Referrals required for certain services through PCP)	Not covered	\$30 copay per visit	80% covered after deductible
Lab Work (Blood Work) Note: Lab Work at a non-preferred non-hospital affiliated lab may not be covered	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	LabCorp and Quest Diagnostics: \$10 copay per visit	Not covered	In-Network Non-Hospital Affiliated Preferred Lab: \$10 copay per visit	80% covered after deductible
					Hospital/Other Lab Facility: \$20 copay per visit		Hospital/Other Lab Facility: \$20 copay per visit	
Basic Imaging/Radiology (i.e., X-Ray, Ultrasound)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit (Referrals required through PCP)	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit	80% covered after deductible
					Hospital Affiliated Facility: \$35 copay per visit (Referrals required through PCP)		Hospital Affiliated Facility: \$35 copay per visit	

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High-Tech Imaging/Radiology (i.e., MRI, CT Scan) Note: Requires a prior authorization	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): \$0 copay per visit	80% covered after deductible
					Hospital Affiliated Facility: \$50 copay per visit		Hospital Affiliated Facility: \$50 copay per visit	
Outpatient Surgery	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Ambulatory Center: \$50 copay per visit	Not covered	Ambulatory Center: \$50 copay per visit	80% covered after deductible
					Hospital Facility: \$100 copay per visit		Hospital Facility: \$100 copay per visit	
Hospital Admission	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	\$100 copay per day with max of \$200 per admission	Not covered	\$100 copay per day with max of \$200 per admission	80% covered after deductible
Center of Excellence (COE)*: The following services are covered under the State of Delaware Group Health Insurance Program (GHIP). Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.								
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Orthopedic (hip replacement/ knee replacement) Note: Requires a prior authorization	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	Not covered	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	80% covered after deductible
					Non-COE Facility: \$500 copay per admission		Non-COE Facility: \$500 copay per admission	
Spine (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/ discectomy procedures) Note: Requires a prior authorization	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	Not covered	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	80% covered after deductible
					Non-COE Facility: \$500 copay per admission		Non-COE Facility: \$500 copay per admission	

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Bariatric Note: Requires a prior authorization	COE Facility* (Preferred): 90% covered after deductible	55% covered after deductible	COE Facility* (Preferred): 90% covered after deductible	55% covered after deductible	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	Not covered	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	55% covered after deductible
	Non-COE Facility: 75% covered after deductible		Non-COE Facility: 75% covered after deductible		Non-COE Facility: 75% covered		Non-COE Facility: 75% covered	
Transplants** (For Highmark plans, does not apply to kidney and bone marrow/stem cell) Note: Requires a prior authorization	COE Facility* (Preferred): 90% covered after deductible	70% covered after deductible	COE Facility* (Preferred): 90% covered after deductible	70% covered after deductible	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	Not covered	COE Facility* (Preferred): \$100 copay per day; \$200 copay max per admission	80% covered after deductible
	Non-COE Facility: 70% covered after deductible		Non-COE Facility: 70% covered after deductible		Non-COE Facility: Not covered		Non-COE Facility: 80% covered	

*Aetna and Highmark Delaware have designated certain health care facilities within their provider network as Centers of Excellence, or simply COE Facilities. COE Facilities have been identified as delivering high quality services and superior outcomes for specific procedures or conditions. This means improved outcomes and reduced cost, which includes delivering surgery and post-operative care more efficiently and with lower risk of complications and readmissions.

**Members are encouraged to review the Highmark or Aetna plan documents for details regarding coverage.

For more information, including plan documents and listings of eligible Urgent Care Centers, COE Facilities and Non-Hospital Affiliated Freestanding Locations for Lab Work and Imaging/Radiology Services, visit the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits.